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Heath Informatics (London & South East) Specialist Group

THE BRITISH COMPUTER SOCIETY

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Editorial

In the March Newsletter, I floated the idea that a paper Newsletter has outlived its usefulness. Over the past year or so, the Committee has noted and reported on the excellent progress and value of the BCS Connect programme. Our membership list is centralised, and available on an e-mail list server. Our finances are centralised, making the Treasurer's job much easier. And, our website has been rehosted and backloaded with goodies.

At the Committee meeting on 12th May, we agreed to make this issue, which happens to be our Golden Edition, the last paper Newsletter. So, let me explain what will take its place.

Parts of the Newsletter, like the Contacts List, are repeated more or less unchanged from issue to issue. This information will appear on the website, to be updated as required.

Parts of the Newsletter, like the programme of future meetings of our own group and of anyone else we hear about, already appear as information or links on our own website and on the websites of others. Website advertising will continue.

The main changeable parts of the Newsletter are the reports from the Committee and from the meetings. Availability of these will improve as they can be put on the website quickly, without the need to wait for enough material to make the postage worthwhile.

The BCS will benefit very directly by not having to photocopy the Newsletter, put it in envelopes and post it. This saves several hundred pounds a year.

There are some other actions which will be put in place.

Already, the e-mail list is used to advertise meetings, and this will continue. The e-mail list cannot be used to send attachments, for which everyone is probably very glad. But, we can now send a short message when a new meeting report is put on the website.

There will need to be a paper brochure for physical publicity, and marketing of our group. The brochure will contain the less changeable information, and will replace using Newsletter copies as handouts.

Mark Buckley-Sharp

Contents

Please see the group website for

- Contacts List
- Membership procedure
- What's On

Website URL at:
www.hilsesg.bcs.org

Committee Report
Wednesday 12th May 2004

The Committee noted the Group's financial position which is healthy now, but we have no income from membership fees, and it is undesirable to handle cash for individual meetings. Members should be aware that holding our list centrally at BCS HQ may be preparatory to charging a membership fee annually. Meanwhile no group membership fee is proposed for 2004/2005.

The Committee agreed to make the next Newsletter the last one on paper, and discussed how to publicise and report activities. (See Editorial for comment.)

Annual General Meeting
Wednesday 12th May 2004

The AGM preceded the main meeting on 12th May, which is reported below.

Barrie Winnard reported on the activities since our previous AGM in January 2003.

Elected Officers were:

Chairman, Barrie Winnard

Treasurer, Moira Watkins

Secretary, Stephen Elgar

President, Mark Buckley-Sharp

Other Committee members include David Hancorn, Andrew Capey, Jas Weir; Sandra Evans.

The debating team at HC2004

Taking a vote

Meeting Report
Wednesday 24th March 2004
Debate

With the NHS Care Records Service project, this House considers that we have "lift-off".

The Group met for its annual debate session during HC2004. As usual, the topic was suitably ambiguous to enable various views to be expressed without too obvious a personal commitment. Chaired by **Keith Clough**, there was a pre-vote before the debate, with 16 expressing a prejudice in favour of the motion, but with 18 edging them out against the motion.

Recognising that he had an uphill struggle, **David Lloyd-Williams** proposed the motion. NPfIT is a huge project, but it has simple aims. Lift-off only requires that we have made a start. For a start, NPfIT has radically changed the face of public sector IT procurement. The change sets down a challenge to remove excuses in implementation. IT is now mainstream in healthcare, and the whole project is being watched closely both beyond the NHS and beyond the UK. Procured with speed; and procured with partnership – that is lift-off. There is now a shift of focus to the frontline and a need to gain momentum. At the least we have some minimum standards to achieve, and acceptance of the programme. Although IT is now a small part of the changes to be made, we must realise that there is no other programme on offer. What choice is there? To seize the chance, or to quibble about what has or has not been done. Uncertainties remain about our ability to implement. For example, PCTs are very stretched. But, there is the will to succeed, and the backing to do so.

Andrew Haw opposed the motion, noting that he had been involved in two previous debates and had been on the winning side both times. The motion considers lift-off, and the two most dangerous parts of a flight are taking off and landing. However, the long-haul flight has its risks too. The procurement to date has been successful, but it is only a fraction of what is required. Is the NHS ready? It cannot just be done by management consultants. Mixing his metaphors, Andrew suggested that the long-haul changes must be made on the ground. The government's e-commerce scheme prescribes an objective review process. Has that been done, and what is the outcome? One test is to ask what

needs to be done for success. Have we agreed the objective – yes we have. But in other areas, the situation is less clear. Have we aligned incentives and rewards? Have we the right skills in place? Have we got respected champions? On these three, the situation is less clear. Was there enough involvement of end users in the procurement? Are our existing IT services ready? And, it would focus minds if IT and NCRS figured in the star ratings for Trusts.

Stephen Elgar seconded the motion by using the example of e-Booking implementation, which is well in hand. E-Booking will go live in three months for some sites in London. His experience is that when NCRS is explained to users and patients, then all are impressed. A recent session for child health specialists was twice oversubscribed. It is agreed that data migration is a big problem, but 68 Trusts in London already have a first line plan to adopt NCRS. Training is a concern, and will be addressed. Meanwhile, the essential use of the NHS number is all transactions will sharpen minds where current usage of the number is too low.

Fleur Fisher seconded the opposition. NCRS could be said to have blasted off, but this is not the same as a successful lift-off. Blast-off can be spectacular, and the NPfIT procurement has been that. But, like Challenger and Columbia, a small fault at lift-off could come back as a big disaster in our future. Have we considered enough of the smaller risks which could lead to disaster? Imagine patients being faced with clinicians backed up with NCRS. Where will be the respect for patient autonomy? NCRS could fail to lift-off or could crash if enough people find it unacceptable – and enough does not have to be as large as a majority. We may want NCRS to lift off, but we must fear a blast off to disaster.

The debate was then opened to the floor. (Contributors are labelled A to H here.)

A) Following Fleur's analogy, we have a nice new rocket, but nothing has been delivered yet, and there are many constraints. We are not there yet.

B) Lift off needs a full fuel tank. (Fleur's analogy was obviously finding widespread sympathy.) Funding for implementation is unidentified.

C) Some defined projects have been identified, but what about the total implementation. When a purchased system appears to be free, it can crowd out existing systems which are still useful. (Ed - I think this is a modern corollary of Gresham's Law.)

D) Other speakers at HC2004 have described 2004 as a time to get ready – a time to clean the pipes. That is not lift off yet.

E) There is a serious risk of public rejection of NCRS when it is deployed.

F) We have the vision; we have the strategy; and we do have the resources. That means lift-off.

G) The national aspects of NCRS are well underway.

H) Continuing the rocket analogy, the engines are fired up. We are committed and ready to go.

Returning to the podium, **Andrew Haw** summed up for the opposition. We sit and worry about NCRS only because we want it to work. So, saying that there is no lift-off yet is not opposition to the programme itself. This is a long term project. As everyone who works with projects knows well – do it right, not do it quickly.

David Lloyd-Williams summed up in favour. We know and agree where we want to go. To arrive, we must start and not stand behind the start line. Breaking the mould on procurement is major progress, and we have started. Now, making NCRS happen depends on that lift-off and on gaining momentum from it. Confidence, hard work and commitment are in place for example, in the LSP for London as described by Stephen. The template for readiness is available. We must judge how effective that is to get on with implementation.

Keith Clough then called for the final vote, which was 23 in favour and 26 against. As usual with our debates, this allows both sides to claim some advantage. The opposers can say that both the before and after votes went their way. Andrew Haw can say he has been on the winning side three times out of three. The proposers can say that they held their vote, that they have nearly half the opinion formers on-side already and that they can only improve.

Once again, the Group has held an interesting and successful event at HC. We can aim to hold another next year, while the fate of NCRS unrolls before us.

HC2004
A Partial View

For those who attend regularly, HC2004 was a curious conference. Many of the issues were so current that it was like watching a river flow past. Just a thought from the comments by **John Hutton** in the opening session. The national spine could be heading for 5 billion transactions per year. At first hearing, that sounds an awful lot. But, put it in context. It's quite possible that the NHS conducts 5 billion such transactions per year already. It seems reasonable to aim to do it all properly, instead of in our current shambolic disorder!!

A workshop discussion was led by **Thomas Jones** of Oracle. The strategy for NPfIT is patient focus. So, patients need to participate in healthcare decisions, and must be able to add to, check and amend their own health records. The majority of people now use the internet to search for health related information, and would use messaging to reduce the need for face to face healthcare. Simple e-mail may not be secure, but patients are happy to use it. When used, it provides 'history' in the patient's own words, and it should be added to the patient's record. Web messaging is even better as messages can be more secure, can be structured, and can be managed by a health team covering individual absences. There are good examples of structured systems improving healthcare team efficiency.

A complete stream on the Tuesday was taken by the NPfIT to explain current progress. This was informative, but not really in a way that I felt able to record succinctly. The sessions proved enormously popular, with crowds spilling in the aisles and back out of the doors. Speakers at other sessions may have been left just talking to each other. I picked up on a comment about the applications quality approach. The NHS has been bad at applications quality assurance, but it should use industry standards. That means testing at the module level; and the system level; and at the integration level. Releases must be formally controlled. Non-standard applications – meaning those outside mainstream NPfIT – can then be added if, and only if, they meet the same standards of compliance testing as within the NPfIT context. Approval of non-standard applications will additionally require an assessment of supplier stability. As NCRS rolls out, existing local solutions with either be made compliant, or they will inevitably go. The welcoming glove may be velvet, but the fist inside will be made of iron.

The conference did not come really alight for me until half way through the last day. 'Leading the Change' launched head on into the real problem we now face with implementing NPfIT as it progresses into NCRS. The Chairman **Brian Edwards** posed some challenges.

- Must we understand the technology? Is this necessary before we use it?
- Pace. There always seems to be something better just over the horizon.
- Leadership. Central control always seems like it's slowing everyone to the slowest, but the benefit will come from tracking the central systems and their timescale.
- Funding. Why is there never enough?
- Build the platform. We are about to see that IT will be more important in changing the delivery and outcome of health care than drugs have been in the past.
- Update the workforce.

Maurice Cheng said that NPfIT is capable of making changes, and now we must make that happen. This requires persuasion of the users; understanding the implications of the change; solving the questions around confidentiality; and using the evidence base for change. The NHS delivers its services from fragmented organisations containing fragmented groups. How ready are we to see the whole NHS brought together in a patient focused service?

Gary Fereday said that IT is often ignored by leaders who see it as risky. IT is delegated to others, and crowded out of the main organisational agenda. Hitting IT targets in every organisation is now critical to timing across the NHS. But, IT change is disruptive, and it cuts across existing boundaries of control. In the new scenario, IT is not about technology; it represents a fundamental process change, and will be the new way of normal working. There are things to do now. We must engage management and their teams; clinicians

and their teams; and we must sort out confidentiality with patients. Organisations need a readiness review; a clinician engagement plan; and management structures in place. Change management needs its own funding, and we must measure the effectiveness of organisations in delivering the changes.

Michael Wilkinson developed the theme of ideas, change, and intellectual property. Change throws up innovations because not everything can be thought of in advance or centrally. How can we harness the ideas for effective change when there is already a backlog of ideas, with poor focus and a poor history of transfer of change for wider application.

Mark Outhwaite popped up again. His several appearances at HC2004 were preceded by a presentation at Radical Steps in February. Managing static businesses has been replaced for many organisations by the need to manage in very unpredictable environments. This demands devolved action so as to recruit the maximum of intellectual capacity. But the NHS has only a poor development of cadres of clinical leaders. With technology developing so fast, it is necessary to have an adequate knowledge of it, even to envisage the changes which are feasible. Otherwise, real change will be too slow. Concatenating from one of his other talks, Mark Outhwaite said that NHS organisations need a checklist.

- Is their leadership in place?
- Is their programme ownership in place?
- Are the logistics in place?
- And, is that applicable not just within the organisation, but shared within the local health community?

A late session on Tuesday was held in the EPR Arms: a realisation of the column in BJHC. A fun session with a serious intent, it was superbly choreographed with audience voting and role play. One-nil to the cynics.

Mark Buckley-Sharp

HC2004
Another Partial View

Glyn Hayes (Mar-22). Health Informatics is coming of age. Multiple organisations and disciplines are involved so we need increased coordination between them to help Health Informatics Professionals. To this end, ASSIST is joining the BCS. It is also important to have a regulatory body and UKCHIP has revised it's website and now offers web-based registration. Remember it's all about the patient and Health Informatics Professionals are at the heart of improvements in patient care. He concluded by urging all to join the BCS and register with UKCHIP, citing "evidence based informatics is the future".

Richard Vincent (Mar-22). "A clinician's view". Reward must be ≥ effort – the key equation in implementation. Early PCs helped managers rather than doctors. Diagnosis is crucially dependent on the data and IT is not a 100% accurate and reliable diagnostic system. With ECG decision IT, 15% of diagnoses may be wildly wrong. Those who know do not need the diagnosis system. Others may act upon a wrong diagnosis.

- Note culture change and management
- Expect initiative development
- Don't ignore subtle sub-systems
- Adopt the language of the user

Dr. Protti (Mar 23). "IM&T Leadership in Healthcare".

The characteristics of the 21st century are that forces are changing the healthcare environment in social, technological and political ways

Types of leaders – Goleman identified 6 basic styles of leadership. The key point is switching between them – using different styles as the circumstances dictate.

Psychology of change management. Adults absorb, experiment and integrate with their existing knowledge. Change takes time and any new system will initially take longer to use before the benefits hopefully become apparent

The Head of IM&T role: Traditionally providing information to the right people at the right time etc. A new role is emerging of improving the performance of people in

an organisation by providing the right time-based information to the right people etc in the right manner.

Bob Grindrod (Mar 23). "Modernising NHS Wales"

The Vision includes:

- A single record
- Workforce empowerment
- Patient and carer empowerment (30% of people changed their lifestyle after they read their own records)
- Service improvement (good ideas need to be worked at to achieve improvement)
- Knowledge and information management standards.

Aidan Laverty

(This contribution by Aidan has been extracted from his original notes which contained information from many of the scientific sessions (also see HC2004 Proceedings), and another commentary about the group's debate session. For further information, please contact Aidan direct, or via our website.)

Meeting Report
Wednesday 12th May 2004
e-Booking

The group met at its usual venue, and heard two interesting presentations. Although not entirely accurate, these might have been called the Bookophile and the Bookosceptic views.

Ray Wagner leads on e-Booking in the SE London SHA. The e-Booking project has very defined aims which should be made clear before expectation runs ahead of the game. The project is to enable direct booking by primary care of a first outpatient appointment in secondary care. Other types of booking eg, primary to primary, or secondary to tertiary referral are not included now, but are obvious extensions for the future.

The booking system mechanism uses a central broking server, working to compliant end systems in primary and secondary care. (The implications of this are extensive and are discussed below.)

The old and existing method of interaction between primary and secondary care can be described as Refer and Book. A referral letter is sent; the letter is reviewed; the appointment is prioritised and made. The patient doesn't get a look in until the end of the process.

The new method is a major change, which can be described as Book and Refer. By meeting any specific criteria for a booking, an appointment can be made directly from primary care onto the secondary system. The referral information follows later.

The NHS Plan target for full e-Booking is end 2005. There have been pilots of both the systems and the business changes. E-Booking was subsequently included within NPfIT, which has brought several offers from suppliers. Inclusion in NPfIT will give national consistency.

Unlike the present system, e-Booking is patient centred. The main benefit is intended to be for the patient. If there is a benefit for clinicians, then that will be a bonus. An obvious improvement is an immediate time slice off the referral process in every case, plus some ability for further optimisation by choosing the provider before making the booking.

The two classes of features built into e-Booking could be called Marketing and Method.

To be bookable at all, and hence to get any business, secondary services will have to be declared in the directory of all services. This requires every secondary organisation to create its service list and corresponding service features. In practice, providers do not have *carte blanche*: they will have to describe services in a national standard way. Most of the bookings guidance may also have to be standardised, although it may be possible for providers to add some customisation. Perhaps the biggest bone of contention could be that purchasers (Primary Care Trusts) can limit the list to those secondary services they have commissioned, so non-commissioned services will not appear as options during booking.

Patients will have several booking methods, of which the most obvious is via the GP system. Each booking will have a unique booking reference (UBR) number. Bookings can be made or altered through a central booking management service which maybe an extension of NHS-Direct.

There could also be a web-based service for personal use. These methods will have to be seamless ie, all accesses will have the current state.

Technical dependencies of e-Booking include compliant end systems, and a working national network spine. The e-Booking servers will not necessarily have real-time appointment availability: synchronisation is more likely to be periodic. Therefore, some appointments may not be confirmed, and will have to be rebooked.

Ray then gave a short demonstration of e-Booking from primary care.

Barrie Winnard is head of IT at Moorfields. He took the role of sceptic to make sure possible problems with e-Booking are kept in mind.

There is limited knowledge about e-Booking amongst the likely user population, and expectations must be managed.

From the GP perspective, there will be the question of whether to book off the desk, or whether to delegate the booking to other staff. To bring forward an item of discussion, the booking process may be enhanced by better review with the patient about of the purpose of the referral, and of the expectation of the outcome. Therefore, to have professional clinical staff do the booking may be an improvement.

Once the initial booking is made, the patient will want to know how the appointment could be changed, and perhaps how to contact the hospital or other provider. This needs to be included as information given to the patient with the booking reference. That all assumes that the patient is capable of managing their own booking. There will be many circumstances eg, language, or disability, where the process must be managed by a carer: yet confidentiality, and fraudulent impersonation of bookings must be avoided.

Hospital IT departments are worried about security on their systems. IT service continuity is another worry if the times requested for downloads of open appointments coincide with time for system maintenance.

The main change is going to be in hospital provider clinical processes when the entire Refer and Book procedure has to be completely replaced by Book and Refer.

Where hospitals are now to be funded by average cost episodes, rather than block and marginal contracting, they will be very vulnerable to reduced business. Therefore, the marketing requirement of e-Booking must be given the highest priority. Those who fail in their marketing will be in real trouble.

There followed a discussion amongst the group of the various issues outlined.

I found this a very interesting meeting because the content changed my views a lot, and the concept of e-Booking really does open up a huge range of possibilities for improvement. Perhaps I should ask why this revelation never happened before, as e-Booking is not new. Perhaps the project should ask why they haven't been getting their message understood more widely.

The main change which strikes me is the issue of marketing of services. As one discussant put it, this is the internal market at last, with the mechanism to deliver it. Marketing services, and gaining the flow of funds which follows, really does shape services. I have experienced that from the way in which pathology laboratories actively trade samples for specialist tests. Just making sure you can describe what you do is a useful management discipline. Picking up the point that purchasers may limit the service list to those already commissioned, one would ask why commissioning is needed at all. With episodes priced at average, who needs contracting or contract monitoring, or even the contracts departments found in every hospital. Let's have unit episode charging, and note that it took a Labour government to specify the technology which finally makes Thatcherism feasible in the NHS.

Mark Buckley-Sharp

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